



**APPLICATION FOR CONTINUATION OF ADOPTION AGREEMENT  
BEYOND AGE EIGHTEEN (18)  
For Recipients of Adoption Assistance Program (AAP)**  
State Form 54713 (R2 / 6-19)  
DEPARTMENT OF CHILD SERVICES

*INSTRUCTIONS: The adoptive parent should complete this application, and obtain the additional required documentation described below. The application and paperwork must be submitted to the Department of Child Services Central Eligibility Unit (CEU) thirty (30) days prior to the child's eighteenth (18<sup>th</sup>) birthday. The Department will review the submitted documentation to determine if the child qualifies for a continuance of adoption assistance and/or Medicaid beyond the age of eighteen (18). Submission of this paperwork does not guarantee continuation of benefits; all cases are reviewed individually, and determinations are made based on set criteria. Adoptive parents should return the completed application and supporting documentation to CEU by fax at (317) 234-4547, email to [Centralized.Eligibility@dcs.IN.gov](mailto:Centralized.Eligibility@dcs.IN.gov) or mail to: Indiana Department of Child Services – Central Eligibility Unit – MS-48, 100 North Senate Avenue, IGCN Room N848, Indianapolis, IN 46204.*

Name of child	Adoptive identification number of child
Name of adoptive parent A	Name of adoptive parent B

Your child currently receives an AAP adoption assistance and Medicaid benefits. To apply for a continuation of these benefits, you must provide CEU with the following:

- A completed "Application for Continuation of Adoption Agreement Beyond Age Eighteen (18)" (this document)
- A completed "Medical Information for Continuation of Adoption Assistance Benefits" (*attached*)
- Supporting documentation of medical condition: Submit supporting documentation, if available, such as an Individual Education Plan (IEP) or other documentation that demonstrates the impact of the child's medical condition on daily functioning.  
(*Note: This item is not required, but may assist in making a determination of eligibility if available to submit with the application.*)

I/ We authorize the Indiana Department of Child Services to request an independent examination and report from a qualified professional selected by the DCS in order to assist DCS in its decision regarding this request for continuation.

I/ We certify that we are legally and financially responsible for the above named child and I / We are entitled to claim the child as a dependent for federal and state income tax purposes during the year(s) requested herein.

I/ We understand that this application and required documentation must be completed and returned to the DCS at least thirty (30) days prior to the child's eighteenth (18<sup>th</sup>) birthday.

I/ We hereby apply for continuation of the adoption agreement and Medicaid on behalf of the child listed above and I/We maintain that all statements and attached documents are accurate and true.

Signature of parent A	Date (month, day, year)
Signature of parent B	Date (month, day, year)
Signature of child	Date (month, day, year)
Mailing address (number and street, city, state, and ZIP code)	
Telephone number (      )	E-mail address



# MEDICAL INFORMATION FOR CONTINUATION OF ADOPTION ASSISTANCE BENEFITS

Part of State Form 54713 (R2 / 6-19)  
DEPARTMENT OF CHILD SERVICES

**INSTRUCTIONS:** This form must be completed and signed by the licensed physician, licensed psychiatrist, or licensed psychologist that treats the child. This form must be submitted, along with the 'Application for Continuation of Adoption Agreement Beyond Age Eighteen (18)' and any supporting documentation, to the Department of Child Services Central Eligibility Unit (CEU) thirty (30) days prior to the child's eighteenth (18<sup>th</sup>) birthday by fax at (317) 234-4547, email at [Centralized.Eligibility@dcs.IN.gov](mailto:Centralized.Eligibility@dcs.IN.gov) or mail to: Indiana Department of Child Services – Central Eligibility Unit – MS-48, 100 North Senate Avenue, IGCN Room N848, Indianapolis, IN 46204.

Name of child		Date of birth (month, day, year)
Date child first seen by your office (month, day, year)		Date child last seen by your office (month, day, year)
Frequency of visits <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every _____ months <input type="checkbox"/> Annually <input type="checkbox"/> Other: _____		

## CURRENT DIAGNOSED MEDICAL CONDITIONS

Complete the requested information for each medical diagnosis. Use an additional page if necessary to document all diagnosed conditions.

### Diagnosis 1

Diagnosis		DSM-V or ICD-9-CM code	Date of onset (month, day, year)
Frequency of symptoms <input type="checkbox"/> Cyclical / episodic <input type="checkbox"/> Continuous / unremitting		Frequency	Severity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
<b>Medication(s)</b>		<b>Dosage(s)</b>	

### Diagnosis 2

Diagnosis		DSM-V or ICD-9-CM code	Date of onset (month, day, year)
Frequency of symptoms <input type="checkbox"/> Cyclical / episodic <input type="checkbox"/> Continuous / unremitting		Frequency	Severity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
<b>Medication(s)</b>		<b>Dosage(s)</b>	

### Diagnosis 3

Diagnosis		DSM-V or ICD-9-CM code	Date of onset (month, day, year)
Frequency of symptoms <input type="checkbox"/> Cyclical / episodic <input type="checkbox"/> Continuous / unremitting		Frequency	Severity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
<b>Medication(s)</b>		<b>Dosage(s)</b>	

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**MEDICAL INFORMATION FOR CONTINUATION OF  
ADOPTION ASSISTANCE BENEFITS (continued)**

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*Describe how the listed diagnoses impact the child's daily level of functioning.*

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*Describe the support or treatment needed to meet the child's needs.*

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Signature of physician

Date (month, day, year)

Printed name of physician

Title of physician